

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-016769

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 206

Primary Registration District No. 2042

Registrar's No. 42

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED APR 16 1963

1. PLACE OF DEATH a. COUNTY <u>MADISON</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>CAPE GIRARDEAU</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>FREDERICKTOWN</u>		c. CITY OR TOWN <u>CAPE GIRARDEAU</u>	
Length of stay in Tb. <u>ONE WEEK</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>MADISON Co. Memorial Hosp</u>		d. STREET ADDRESS (If outside, give location) <u>525 CORDELIA</u>	
Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>RAYMOND</u> Middle <u>RICHARD</u> Last <u>HICKS</u>			4. DATE OF DEATH Month <u>APRIL</u> Day <u>8</u> Year <u>1963</u>		
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>11-28-1891</u>	9. AGE (last birthday) <u>71</u>	IF UNDER 1 YEAR Months <u>4</u> Days <u>10</u> Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>DENTIST</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (City and state or country) <u>YOUNT, MO.</u>	
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13a. FATHER'S NAME <u>BENJAMIN HICKS</u>		13b. MOTHER'S MAIDEN NAME <u>MARGARET COUNTS</u>	
14. NAME OF HUSBAND OR WIFE <u>NONE</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>205 DELMAR</u>	
17. INFORMANT <u>WILLARD HICKS, FREDERICKTOWN, MO.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma General of Intestine</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u>	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I.(a) <u>—</u>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u>—</u>	
20c. TIME OF INJURY Hour <u>—</u> a.m. <u>—</u> p.m. <u>—</u> Month, Day, Year <u>—</u>	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>—</u>	20f. CITY, TOWN, OR LOCATION <u>—</u>
21. I attended the deceased from <u>April 2, 1963</u> to <u>April 8, 1963</u> and last saw him alive on <u>April 8, 1963</u> Death occurred at <u>3:30 P.M. April 8</u> on the date stated above, and to the best of my knowledge, from the causes stated:		22a. SIGNATURE (Degree or title) <u>H. C. Slaughter M.D.</u>	
22b. ADDRESS <u>1135 West Main, Fredericktown, Mo.</u>		22c. DATE SIGNED <u>April 9, 1963</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>4-10-63</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Whitewater Christian Cem.</u>	23d. LOCATION (City, town, or county) <u>YOUNT, MO.</u>
24. FUNERAL DIRECTOR <u>SAM NAJIM, JR.</u>	ADDRESS <u>FREDERICKTOWN, MO.</u>	25. DATE RECD. BY LOCAL REG. <u>4-10-1963</u>	26. REGISTRAR'S SIGNATURE <u>Flarence Hicker</u>

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

APR 19 1963

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Charles F. Deiss Jr.

Licensed Embalmer No. 5119

P. O. Address 218 E. College
Fredricktown Missouri

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.